ID	Question	Discussion	Answer	Last Updated
20100018	Reportability--Hematopoietic, NOS: Is this case reportable? See Discussion.	A patient was diagnosed with light chain disease based on SPEP and urine testing.(2010 case) Bone marrow aspiration and biopsy were done. Flow cytometry, cytogenetic studies and FISH for plasma cell disorders are all normal. Medical Oncologist states diagnosis as light chain disease. Patient was started on Revlimid, dexamethasone and Velcade. I reviewed the case reportability instructions and felt this fell under Instruction 1, note 1. Immunoglobulin deposition disease (preferred term for light chain disease) codes out to a 9769/1. This is normally a nonreportable diagnosis but if I am interpreting the instructions right, I would abstract this case using the above morphology code and Primary site of bone marrow. Would this be correct?	This case is not reportable. Light chains are produced in neoplastic plasma cells (multiple myeloma) and are called Bence-Jones proteins. That is why your physician did the cytogenetic studies and FISH to rule out plasma cell disease. 50-60% of people with Light-chain deposition disease (LCDD) have an associated lymphoproliferative disorder, most commonly multiple myeloma. The remaining patients develop LCDD in the setting of progression of monoclonal gammopathy of unknown significance (MGUS) with no evidence of neoplastic plasma cell proliferation. Your patient falls in this category, MGUS, which is not reportable.	07/01/10
20100015	Type of Multiple Tumors/Multiplicity Counter--Breast. Are the data items "Type of Multiple Tumors Reported as One Primary" and "Multiplicity Counter" related? How should they be coded for breast cases in which there are multiple measured invasive tumors, plus DCIS which is not measured nor stated whether it is separate from the invasive tumors? See Discussion.	For example, path report states only "multifocal invasive ductal carcinoma, 1.5 cm and 0.8 cm, and low-grade DCIS." Since the Multiplicity Counter instructions tell us to ignore/do not count foci that are not measured, we interpret this to mean, count only the two invasive foci and ignore the DCIS. Should Type of Multiple Tumors then be coded 30 or 40, since only the invasive tumors were coded in Multiplicity Counter?	Code Type of Multiple Tumors 30 [in situ and invasive]. The code in Type of Multiple Tumors may or may not reflect the tumors that were counted in Multiplicity Counter. For this case, it is correct to code 02 in multiplicity counter.	07/01/10
20100012	Date of diagnosis--Breast: A mammogram report indicates "suspicious calcifications" without defining what the calcifications are suspicious for, and gives a BIRADS category of 4. A biopsy of the site several days later revealed ductal carcinoma. Should I use the mammogram date or the bx date as the date of diagnosis? See Discussion.	The date of diagnosis is the date when cancer was first diagnosed by a recognized medical practitioner, whether clinically or microscopically confirmed. The ambiguous terminology that constitutes the diagnosis is listed in the FORDS, part I, pages 3-4. There are no BIRADS categories listed there, therefore, should not be used by the registrar to determine the earliest date of diagnosis. Also, the term "suspicious for calcification" is not reportable, because calcification is benign condition, unless the physician describes it as malignant. Reference: 46637 12/29/2009 FORDS In the last paragraph is a statement no BIRAD categories listed...cannot be used to determine earliest date of diagnosis. Is this to be followed by the SEER Program?	The date of diagnosis for this case is the date of the biopsy. There is no reportable diagnosis on the mammogram.	07/01/10
20100011	Reportability: Is this benign tumor reportable based on metastasis to a regional lymph node? See Discussion.	"Periampullary duodenum, resection: Gangliocytic paraganglioma, with metastasis to one large periduodunal lymph node. Six other small lymph nodes negative. See comment. Comment: The primary tumor in the duodenum is made up mainly endocrine cell component. This component appears to have metastasized to a periduodenal lymph node."	This neoplasm is reportable because it is malignant as proven by the lymph node metastases. Code the behavior as malignant (/3) when there are lymph node metastases.	07/01/10
20100010	MP/H Rules/Multiple primaries--Ovary: Do we abstract as 1 primary or 2 separate primaries becasue rule M7 says "Bilateral epithelial tumors (8000-8799) of the ovary within 60 days are a single tumor." Does this mean that the tumors in each ovary must be anywhere in this histology range...or must they be the	Patient had bilateral ovarian tumors - right ovary showed serous cystadenocarcinoma and left ovary had clear cell adenocarcinoma. Pathology comment said: Based on the histologic differences of the tumors within each ovary, feel these represent two distinct separate primaries. LN mets are clearly	Apply rule M8 and abstract this case as multiple primaries. Rule M7 does not apply when each ovary has a distinctly different histology, even when both histologies are with the specified code range. This clarification	07/01/10

	SAME histology AND in the specified range to be one primary? See Discussion.	serous ca. Physician staged rt tumor as T2a N1 M0 and left ovary as T1c N0 M0.	will be added to the next version of the rules.	
20100008	Primary site--Unknown & ill-defined site: Hospital A says the primary site is bladder, because of their molecular study report. Hospital B says this is an unknown primary. Which is correct? Do we take primary site from these tests, even when no clinical correlation is documented? See Discussion.	Patient seen in 2009 at Hospital A for bone pain and found to have metastatic adenocarcinoma. A paraffin block specimen was sent to BioThernostics for THEROS CancerTYPE ID Molecular Cancer Classification Tests. The results came back with a 94% likelihood that the urinary bladder was the primary site. No scans were done on the abdomen or pelvis. The patient was the sent to Hospital B for radiation to the bones and chemotherapy (Carboplatin and Taxol). The patient died within 6 months.	Code primary site to bladder in this case. Code the known primary site when given the choice between a known primary site and an unknown primary site.	07/01/10
20100007	MP/H Rules/Histology--Melanoma: Regarding SINQ #20081044 and Rule H5 and Rule H6 for cutaneous malignant melanoma. What is the difference between the two rules? When would you move on to Rule H6 since you would normally always have a specfic cell type.		Rule H6 is used when you do not have a specific cell type other than regressing melanoma, or malignant melanoma, regressing. If you have regressing melanoma with a specific cell type, apply rule H5.	07/01/10
20100006	MP/H Rules/Multiple primaries--Kidney, renal pelvis: Would the following be a new primary, if so, what site code would be used? See Discussion. Original slides were not reviewed and the mass was not described as being metastatic. If you consider the renal fossa soft tissue mass as a new tumor, the MP rules for 'Other Sites' directs you to code it as a new primary based on rule M10 (dx'd more than one year apart). Is this correct or would you consider it a recurrence of the original kidney primary?	Pt dx'd with clear cell ca of rt kidney in 2003, treated with nephrectomy. Tumor was limited to kidney. An FNA of the pancreas in 11/07 showed 'changes c/w mets renal cell ca.' In 2009 the pt was found, on CT, to have a mass in the rt renal fossa and an FNA was positive for malignancy. On 8/26/09 an excision of the mass showed 'recurrent renal cell ca, clear cell.' The specimen was labeled as 'soft tissue, rt renal fossa.'	This is not a new primary. The patient has metastatic disease from the 2003 kidney primary. Clear cell carcinoma metastasized to the pancreas in 2007 and to the right renal fossa in 2009.	07/01/10